adverse determination, the HMO or CMP must prepare a written explanation and send the entire case to HFCA. HCFA makes the reconsidered datermination.

(c) The HMO or CMP must issue the reconsidered determination to the enrollee, or submit the explanation and file to HCFA within 60 calendar days from the date of receipt of the request for reconsideration. In the case of an expedited reconsideration, the HMO or CMP must issue the reconsidered determination as specified in §417.617(c)(3) or submit the explanation and file to HCFA within 24 hours of its determination, the expiration of the 72-hour review period, or the expiration of the extension.

(d) For good cause shown, HCFA may allow extensions to the time limit set forth in paragraph (c) of this section.

(e) Failure by the HMO or CMP to provide the enrollee with a reconsidered determination within the time limits described in paragraph (c) of this section or to obtain a good cause extension described in paragraph (d) of this section constitutes an adverse determination, and the HMO or CMP must submit the file to HCFA.

(f) If the HMO or CMP refers the matter to HCFA, it must concurrently notify the beneficiary of that action.

[59 FR 59942, Nov. 21, 1994, as amended at 62 FR 23376, Apr. 30, 1997]

§ 417.622 Reconsidered determination.

A reconsidered determination is a new determination that—

(a) Is based on a review of the organization determination, the evidence and findings upon which it was based, and any other evidence submitted by the parties or obtained by HCFA or the HMO or CMP; and

(b) Is made by a person or persons who were not involved in making the organization determination.

[50 FR 1346, Jan. 10, 1985, as amended at 59 FR 59941, 59942, Nov. 21, 1994]

§ 417.624 Notice of reconsidered determination.

(a) *Responsibility for notice.* The entity that makes the reconsidered determination is responsible for mailing notice to the parties and, if that entity is not HCFA, for sending a copy to HCFA.

(b) *Content of notice.* The notice must—

(1) State the specific reasons for the reconsidered determination;

(2) Inform the party of his or her right to a hearing if the amount in controversy is $100 or more; and

(3) Describe the procedures that the party must follow to obtain a hearing.

[50 FR 1346, Jan. 10, 1985]

§ 417.626 Effect of reconsidered determination.

A reconsidered determination is binding on all parties unless a request for a hearing is filed in accordance with the provisions of §417.632, or unless it is revised in accordance with §417.638.

[50 FR 1346, Jan. 10, 1985, as amended at 62 FR 25855, May 12, 1997]

§ 417.630 Right to a hearing.

If the amount remaining in controversy is $100 or more, any party to the reconsideration who is dissatisfied with the reconsidered determination has a right to a hearing. (The amount remaining in controversy, which can include any combination of Part A and Part B services, is computed in accordance with §405.740 of this chapter for Part A services and §405.820(b) of this chapter for Part B services. If the basis for the appeal is the refusal of services, the projected value of those services is used in computing the amount remaining in controversy.)

[59 FR 59942, Nov. 21, 1994]

§ 417.632 Request for hearing.

(a) *Method and place for filing a request.* A request for a hearing must be made in writing and filed at one of the places specified in §417.616(a).

(b) *Time for filing a request.* Except when the time is extended by an ALJ as provided in 20 CFR 404.933(c), a request for a hearing must be filed within 60 days of the date of the notice of reconsidered determination.

(c) *Parties to a hearing.* (1) The parties to a hearing must be the parties to the reconsideration and any other person or entity whose rights with respect to the reconsideration may be affected by the hearing, as determined by the ALJ.

(2) The HMO or CMP must be made a party to the hearing but does not have a right to request a hearing.

(d) *ALJ action when the amount in controversy is less than $100.* (1) If the request plainly shows that the amount in controversy is less than $100, the ALJ dismisses the request.

(2) If, after a hearing is initiated, the ALJ finds that the amount in controversy is less than $100, he or she discontinues the hearing and does not rule on the substantive issues raised in the appeal.

[50 FR 1346, Jan. 10, 1985; 50 FR 20570, May 17, 1985, as amended at 60 FR 46234, Sept. 6, 1995; 62 FR 25855, May 12, 1997]

§ 417.634 Departmental Appeals Board (DAB) review.

Any party to the hearing, including the HMO or CMP, who is dissatisfied with the hearing decision, may request the DAB to review the ALJ's decision or dismissal. Regulations beginning at 20 CFR 404.967 regarding SSA Appeals Council Review are applicable to DAB review for matters addressed by this subpart.

[62 FR 25855, May 12, 1997]

§ 417.636 Court review.

(a) *Review of ALJ's decision.* A party or the HMO or CMP may request judicial review of an ALJ's decision if—

(1) The Departmental Appeals Board denied the party's or the HMO's or CMP's request for review; and

(2) The amount in controversy is $1,000 or more.

(b) *Review of Departmental Appeals Board decision.* A party or the HMO or CMP may request judicial review of the Departmental Appeals Board decision if—

(1) It is the final decision of HCFA; and

(2) The amount in controversy is $1,000 or more.

(c) *Request for review.* The civil action must be filed in a district court of the United States in accordance with section 205(g) of the Act (see 20 CFR 422.210 for a description of the procedures to follow in requesting judicial review).

[50 FR 1346, Jan. 10, 1985, as amended at 58 FR 38083, July 15, 1993; 61 FR 32348, June 24, 1996]

§ 417.638 Reopening determinations and decisions.

An organization, reconsidered, or revised determination made by an HMO, CMP, or HCFA, or a decision or revised decision of an ALJ or the Departmental Appeals Board, may be reopened in accordance with the provisions of § 405.750 of this chapter.

[59 FR 59942, Nov. 21, 1994, as amended at 61 FR 32348, June 24, 1996]

Subpart R—Medicare Contract Appeals

SOURCE: 50 FR 1346, Jan. 10, 1985, unless otherwise noted.

§ 417.640 Determinations subject to appeal.

This subpart establishes the procedures for making and reviewing the following initial determinations:

(a) A determination that an HMO or CMP is not qualified to enter into a contract with HCFA under section 1876 of the Act.

(b) A determination that an HMO or CMP is qualified only for a reasonable cost contract.

(c) A determination to terminate, or to refuse to renew, a contract with an HMO or CMP because—

(1) The HMO or CMP has failed substantially to carry out the terms of the contract;

(2) The HMO or CMP is carrying out the contract in a manner that is inconsistent with the efficient and effective administration of section 1876 of the Act;

(3) The HMO or CMP no longer meets the applicable conditions necessary to qualify as an HMO or CMP under section 1876 of the Act and this subpart; or